



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

RENAISSANCE HOSPITAL  
C/O BURTON & HYDE PLLC  
PO BOX 684749  
AUSTIN TX 78768-4749

#### **Respondent Name**

AMERICAN HOME ASSURANCE COMPANY

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-06-2869-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "In this case, the carrier has not submitted any case specific analysis or methodology to justify its rate or reimbursement. As such, Renaissance Hospital should be reimbursed at its usual and customary rate per Texas Labor Code Sec. (413.011(b)). This is a directive by the legislature. State Of Risk Management is not at liberty to supersede the authority of the Commission."

**Amount in Dispute:** \$12,917.74

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "After further review of the additional documents the original audit stands, the Requestor was previously reimbursed fairly and reasonably."

**Response Submitted by:** Hoffman Kelley LLP, 400 West 15<sup>th</sup> Street, Suite 700, Austin, Texas 78701

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2005 to May 13, 2005	Outpatient Services	\$12,917.74	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes
2. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that

specific fee guidelines are established by the commission.”

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. This request for medical fee dispute resolution was received by the Division on December 27, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on January 6, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. U.S. Bankruptcy Judge Michael Lynn issued a “STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS,” dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the Claim Adjudication Process as to the Workers’ Compensation Receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 Trustee of the debtor’s estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer’s behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 426 – REIMBURSED TO FAIR AND REASONABLE.
  - 253 – IN ORDER TO REVIEW THIS CHARGE WE WILL NEED A COPY OF THE INVOICE.
  - 921 – COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM – UR/JE
  - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE
  - W10 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REIMBURSEMENT MADE BASED ON INSURANCE CARRIER FAIR AND REASONABLE

## **Findings**

1. 28 Texas Administrative Code §133.307(e)(2)(A), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include “a copy of all medical bill(s) as originally submitted to the carrier for reconsideration...” Review of the documentation submitted by the requestor finds that the request does not include a copy of the medical bill(s) as originally submitted to the carrier for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(A).
2. 28 Texas Administrative Code §133.307(e)(2)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include “a copy of each explanation of benefits (EOB)”... “relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB.” Review of the documentation submitted by the requestor finds that the request does not include a copy of the EOB detailing the insurance carrier’s response to the request for reconsideration. Nor has the requestor submitted convincing evidence of carrier receipt of the provider request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(B).
3. 28 Texas Administrative Code §133.307(g)(3)(A), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including “documentation of the request for and response to reconsideration (when a provider is requesting dispute resolution on a carrier reduction or denial of a medical bill) or, if the carrier failed to respond to the request for reconsideration, convincing evidence of the carrier’s receipt of that request.” Review of the submitted evidence finds that the requestor has not provided documentation of the insurance carrier’s response to the request for reconsideration or convincing evidence of the carrier’s receipt of that request. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(A).
4. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include

“how the submitted documentation supports the requestor position for each disputed fee issue.” Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor’s position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).

5. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:
- The requestor’s position statement asserts that “...Renaissance Hospital should be reimbursed at its usual and customary rate per Texas Labor Code Sec. (413.011(b)... Renaissance Hospital has taken the following into consideration when determining the facility’s usual and customary fee for service: 1) The time and labor required, the uniqueness and/or difficulty of the Procedures(s) and /or service(s) performed, and the skill required to perform the he same properly; 2) The likelihood that the time involved in performing the procedures(s) and /or services(s) will preclude the treatment of other patients for remuneration by the healthcare provider; 3) The professional fee customarily charged in the locality for similar medical services; 4) The time limitations imposed by the patient or by the circumstances, i.e., the handling of adverse reactions or complications; 5) The nature and length of the professional relationship with the patient and / healthcare facility and: 6) The experience, reputation, and ability of the healthcare provider performing the procedure(s) and /or service (s).”
  - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
  - The requestor did not submit documentation to support the time and labor required to perform the services in dispute.
  - The requestor did not submit documentation to support the uniqueness and/or difficulty of the services in dispute.
  - The requestor did not submit documentation to support the skill required to properly perform the services in dispute
  - The requestor did not submit documentation to support the likelihood that the time involved in performing the services in dispute would preclude the treatment of other patients for remuneration by the healthcare provider.
  - The requestor did not submit documentation to support the professional fee customarily charged in the locality for similar medical services.
  - The requestor did not submit documentation to support the time limitations imposed by the patient or by the circumstances in rendering the services in dispute.
  - The requestor did not submit documentation to support the experience, reputation, and ability of the healthcare provider performing the services in dispute.
  - The requestor did not explain or demonstrate how the above information supports the amount charged as their usual and customary fee.
  - The requestor does not discuss or explain how the above information supports the requestor’s position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
  - The Division has previously found that “hospital charges are not a valid indicator of a hospital’s costs of providing services nor of what is being paid by other payors,” as stated in the adoption preamble to the Division’s former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that “Alternative methods of reimbursement were considered... and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges...” 22 *Texas Register* 6268-6269. Therefore, the use of a hospital’s “usual and customary” charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
  - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
  - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
  - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

## **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amounts sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rule at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

## **Authorized Signature**

_____	<u>Grayson Richardson</u>	<u>February 29, 2012</u>
Signature	Medical Fee Dispute Resolution Officer	Date

## ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**